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Nos. 95-1858, 96-110

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

v.

Petitioners,

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

v.

Petitioners,

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

On Writs Of Certiorari To The United States Courts Of Appeals For The Second And Ninth Circuits

BRIEF *AMICI CURIAE* OF AMERICANS FOR DEATH WITH DIGNITY AND THE DEATH WITH DIGNITY EDUCATION CENTER IN SUPPORT OF RESPONDENTS

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INTERESTS OF AMICI*

Americans for Death With Dignity is a California nonprofit corporation. Its constituency, numbering approximately 25,000 persons, includes physicians, clergy, attorneys, terminally ill persons, their friends and families, and others who support the right to physician aid in dying for mentally competent, informed, terminally ill adults.

Americans for Death with Dignity wrote, qualified, and sponsored Proposition 161, an initiative on the November 1992 general election ballot in California. Proposition 161 would have given competent, informed, terminally ill patients the right to request and receive physician aid in dying. Despite a well financed opposition, the measure received 4,562,010 votes, or 46% of the votes cast.

Americans for Death with Dignity believes that a competent, terminally ill adult has a right to choose a peaceful, pain-free and dignified death. For many terminally ill persons, this right cannot be humanely exercised without the aid of a compassionate physician. Americans for Death with Dignity supports reasonable regulation of access to physician aid in dying to ensure that it is not abused.

The Death with Dignity Education Center, based in San Mateo, California, is a national not-for-profit 501(c)(3) organization, founded in 1994. Its mission is to promote a comprehensive, humane, responsive system of care for terminally ill patients.

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*This Brief is filed with consent of all the parties. The letters granting consent are separately lodged.

The Center fosters discussion about physician aid in dying, provides a common meeting ground for dialogue and consensus-building, and develops effective goal-oriented strategies for advancing issues related to end of life care. It serves as an information resource for the public and the media, providing factual, up-to-date information that is balanced, authoritative, and understandable. It extends outreach to established constituencies and professional organizations to encourage them to become involved in the discourse and deliberation surrounding these issues. The Center's goal is to develop the framework for public consensus and the messages that will support it.

INTRODUCTION

How can a competent, terminally ill adult end her suffering and lawfully hasten death in the State of Washington?

> She can take a gun to her head, if she can get it and dares to use it.
>
> If she is lucky enough to be on a life support system she can have a physician disconnect the system and thus die "naturally" by starvation, dehydration or suffocation.
>
> But she can't have a physician prescribe a medication that will bring a quiet, painless and dignified end to her suffering.

The State thus places a higher value on "allow[ing] the disease process to follow a natural course to death,"

Pet. Br. 12,[1] than it does on self-determination, ending suffering and sustaining dignity. That is the crux of the State's position at virtually every step of the argument in this case. The State's view of the Constitution – and, indeed, of life – is cruel, degrading, arbitrary and wrong. The Court should affirm the court of appeals' decision and affirm individual liberty against state power. Anything less would be uncivilized.

ARGUMENT

This case presents one of the great issues of our day: the right of mentally competent, terminally ill adults to exercise their constitutionally protected right of self-determination and individual liberty by hastening death with the assistance of a physician. But, while this issue is great, it is also narrow. Unlike the traditional "suicide" who intends to take his life, the terminally ill person who seeks physician aid in dying does not have the primary goal of ending his life – nature has taken care of that. The person who seeks physician aid in dying wants to end his suffering by shortening the dying *process*. No state has a legitimate interest in prolonging the suffering of the dying.

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[1] Citations to "Pet. Br." refer to the Brief Submitted by Petitioners in *Washington v. Glucksberg*, Case No. 96-110. This brief is filed primarily in response to the arguments made by the State of Washington in the *Glucksberg* case. However, the arguments presented in this brief apply with equal force to the other case before this Court, *Vacco v. Quill*, Case No. 95-1858.

I. THE CONSTITUTION PROTECTS THE RIGHT OF A TERMINALLY ILL ADULT TO HASTEN DEATH.

The constitutionally protected right to self-determination and personal autonomy encompasses the right of a terminally ill adult to end his or her suffering by hastening death with the aid of a physician. The right to self-determination and personal autonomy is imbedded in our nation's tradition. More than a hundred years ago, this Court declared:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

The Court has relied upon this deeply-rooted right to protect an individual's freedom to decide the course of his or her life. For example, this Court invoked the "liberty interest" to protect the right to procreate, *Skinner v. Oklahoma*, 316 U.S. 535 (1942); to protect personal decisions relating to marriage, *Loving v. Virginia*, 388 U.S. 1 (1967); to protect the rights of both married and unmarried persons to use and have access to contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); and to protect a woman's right to have an abortion. *Roe v. Wade*, 410 U.S. 113 (1973).

The Court stated the principle eloquently in *Casey*:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 851 (1992).

Like other "liberty interests," the right of a terminally ill adult to determine the time, place, and manner of her death involves "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Casey*, 505 U.S. at 851. Like a woman who faces an unwanted pregnancy, a terminally ill patient faces "suffering [that] is too intimate and personal for the State to insist, without more, upon its own vision . . . however dominant that vision has been in the course of our history and culture." *Id.* at 852.

Indeed, in *Cruzan* this Court recognized that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 281 (1990). The *Cruzan* dissenters agreed:

> Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental."

Id. at 343 (Stevens, J., dissenting) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

> Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.

Cruzan, 497 U.S. at 310-11 (Brennan, J., dissenting).

In *Cruzan*, the Court concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. Implicit in this statement is the principle that a competent, terminally ill person has a constitutionally protected liberty interest in hastening death, since refusing life-sustaining medical treatment is choosing to die sooner rather than later. In short, this Court in *Cruzan* recognized that a terminally ill patient has a right to hasten death by effectively starving herself to death.

The State not only agrees that such a right exists, Pet. Br. 12, but protects it by statute. RCW § 70.122.010, *et seq.* Accordingly, the State allows a competent, terminally ill person to starve herself to death but does not allow her to ease her way into death by the use of physician-prescribed medication. This position is irrationally cruel, and the State fails to identify any significant difference, in terms of the liberty interest, between these two situations.

Mrs. B's experience aptly illustrates this false dichotomy. At age sixty, Mrs. B had suffered from an aggressive form of breast cancer for ten years. After five years of frequent hospitalizations, surgeries, hormonal therapies, chemotherapy, and radiation, she was rendered bed-

bound and housed in a nursing facility. As she became weaker, and could neither read nor take care of her basic bodily functions, she found her continued "living" unbearable. She turned to her physician for assistance in ending her suffering. After consulting with the hospital ethics committee, the physician outlined the only method by which she could help – Mrs. B would be given intravenous morphine and sedation to leave her unconscious, then be "allowed to die" of dehydration. After saying good-bye to her family and friends, Mrs. B was given the medications intravenously. She lingered for ten days in an unconscious state before succumbing to dehydration. *See* Timothy Quill, *Death and Dignity: Making Choices and Taking Charge* (1993), 111-112.

Moreover, the withdrawal of life-sustaining treatment is no less an *active* step hastening death than the provision of a prescription in response to a competent, terminally ill adult's request. In fact, the act of removing a respirator or withholding life-sustaining nutrition or hydration may be far more intrusive than prescribing medication. When a physician removes a respirator or withholds nutrition or hydration, the patient will die. When a physician prescribes medication, the patient may or may not choose to take the medication. In both instances, it is the patient's wish that operates to hasten death.

Thus, the right of a mentally competent, terminally ill adult to hasten death is a liberty interest protected by the

Due Process Clause from unwarranted governmental interference.[2]

II. THE RIGHT TO END PERSONAL SUFFERING OUTWEIGHS ANY STATE INTEREST IN PROLONGING THE DYING PROCESS.

This liberty interest must be balanced against any competing interests a state might have. *Cruzan*, 497 U.S. at 279. However, the state may not destroy – outright or through restrictions that have the same effect – an individual's ability to exercise his liberty interests. *Casey*, 505 U.S. at 857, 874 ("a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims;" state regulations which impose an "undue burden" on a woman's ability to make the decision to terminate her pregnancy violate the Due Process Clause).

A. The State's Asserted Interests Are Weak.

Although the State asserts a number of interests in banning physician aid in dying, those interests pale in comparison to the interests of the terminally ill people who wish to humanely hasten the dying process.

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[2] Since there is no constitutionally cognizable difference between allowing a person to starve herself to death and allowing a person to hasten death through the use of physician-prescribed drugs, the statute at issue in this case also violates the Equal Protection Clause.

1. Preservation of Life

The State argues that its interest in preserving life outweighs the right of an individual to hasten death with the aid of a physician. Pet. Br. 33-38. This argument ignores a long line of cases, from this Court and others, that recognizes that the state's interest in preservation of life is neither absolute nor static. Rather, the state's interest in preservation of life varies depending on the stage and quality of life at issue.

As various abortion decisions and the "end-of-life" decisions demonstrate, the state's interest in preserving life is strongest in the middle point of the continuum, after viability and throughout an adult's healthy productive years. As an individual approaches death, the state's interest in preservation of life weakens. *See, e.g., Cruzan*, 497 U.S. at 271 (quoting *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977)) (state's interest is "greatest when an affliction [is] curable" and less so when " 'the issue is not whether, but when, for how long, and at what cost to the individual [a] life may be briefly extended' "); *Brophy v. New England Sinai Hosp., Inc.* 497 N.E.2d 626, 635 (Mass. 1986) (same); *Roe v. Wade*, 410 U.S. 113, 163 (1973) (describing the state's interest in life as gradually increasing during pregnancy relative to the individual's interest); *Casey*, 505 U.S. at 869 (same); *Matter of Quinlan*, 355 A.2d 647, 663-64 (state's interest in preserving life "weakens and the individual's right to privacy grows as the degree of bodily invasion increases as the prognosis dims"), *cert. denied sub nom., Garger v. New Jersey*, 429 U.S. 922 (1976); *Rasmussen by Mitchell v. Fleming*, 741 P.2d 674, 683 (Ariz. 1987)

(state's interest in preserving life "necessarily weakens and must yield to the patient's interest" where treatment "serves only to prolong a life inflicted with an incurable condition"); *McKay v. Bergstadt*, 801 P.2d 617, 622 (Nev. 1990) ("as the quality of life diminishes because of physical deterioration, the State's interest in preserving life may correspondingly decrease").

At either end of the continuum – before viability and near death – the individual's personal autonomy interest outweighs the state's abstract interest in "preserving life." The terminally ill individuals whose rights are at issue here are at the very end of this continuum, suffering through the final stage of life with no hope of recovery. When a person approaches death and judges continued suffering and degradation to be unbearable, there is no principled state interest in forcing that person, against her will, to prolong the suffering and dying process.[3]

Indeed, the State admits that there is a "well settled" right to hasten death by refusing life-sustaining medical treatment, including refusal of nutrition and hydration. Pet. Br. 12. *See, e.g., In re Guardianship of Grant*, 747 P.2d 445 (Wash. 1987), *amended*, 757 P.2d 534 (Wash. 1988). It apparently believes its interest in preserving life must yield to that right because hastening death through

[3] Similarly, Washington contends that physicians must act only for "therapeutic purposes." Pet. Br. 13. Is it "therapeutic" to prolong life and suffering when death is certain and imminent? Is it therapeutic to remove a patient's food and water to hasten death because of her "physiological inability to chew or swallow," Pet. Br. 38, but not to give that same patient a prescription for medication that will bring a painless and dignified end to her suffering?

refusal of medical treatment "allows the disease process to follow a natural course to death" – which may be "set in motion by [the patient's] physiological inability to chew or swallow." Pet. Br. 38, citing *In re Gardner*, 534 A.2d. 947, 955-56 (Me. 1987).[4]

The State's "preservation of life" rationale thus rests on a cruel and untenable preference for death by starvation or dehydration, which will likely cause suffering for well over a week, over a quick, painless and dignified death through self-administered medication. Surely the Court would not condone such a state preference were this an Eighth Amendment case.

2. "Erroneous" Deaths.

The State also argues that it has an interest in prohibiting "deaths that occur as a result of errors in medical or legal judgment." Pet. Br. 34. Its premise is that "it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is impossible to say for certain whether a borderline individual is or is not mentally competent." Pet. Br. 34.

This argument is disingenuous. Washington, like many other states, has already legislated such issues. The Natural Death Act defines "Terminal condition" as:

[4] Moreover, under Washington law, one need not even be in a persistent vegetative state to refuse nutrition and hydration. *See* RCW § 70.122.010 *et seq.* A fully conscious terminally ill person could lawfully hasten his death by refusing life-sustaining nutrition and hydration.

> an incurable and irreversible condition caused by injury, disease, or illness, that within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

RCW § 70.122.020(9). The Legislature recognized that a directive to withhold or withdraw life-sustaining treatment may remain in effect if the declarant "becomes comatose or is rendered incapable of communicating with the attending physician." RCW § 70.122.040(3). Thus, in the context of refusing medical treatment, the Legislature has already come to terms with the issues of defining terminal illness. Those issues are no more complicated in the present context.[5]

The State also pejoratively skews the issue of mental competence. Quoting from a report of the Washington Legislative Council Committee, Dec. 3, 1970, it asserts, "[A potential suicide] is in all probability a troubled, disturbed human being who needs psychiatric care or

[5] Indeed, if terminally ill adults know that assistance is available, and that they can remain in control of their deaths, that knowledge may actually increase the will to live for many who would otherwise contemplate immediate suicide. "The fear and anxiety that many people feel when contemplating chronic and terminal debilitating illness is rooted, at least in part, in the fear that their suffering will be prolonged by medical technology and that they will have little or no control over its application." Christine K. Cassel, M.D. & Diane E. Meier, M.D., *Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide*, 323 No. 11, New Eng. J. Med., 750, 751 (Sept. 13, 1990).

some other counseling service." Pet. Br. 5. It also characterizes a suicide attempt as "indicative of a mental disorder. . . . " *Id.* at 23. While all this may be true of suicide attempts in the general population, this case deals with the narrow group of mentally competent, terminally ill adults who are already dying. In that context, to request a physician's assistance in hastening death is rational, not remotely "indicative of a mental disorder."

If the State wants to engage in definitional quibbles, it should recall that the statute makes a criminal of one who "aids a suicide." But is honoring a choice to end suffering and indignity by hastening an imminent death "aiding suicide"? Is that more like "suicide" than choosing to suffocate by having a respirator removed? And is removing that respirator – an act expressly sanctioned by the State – something less than "aiding"?

In fact, these "definitional" problems are paper tigers. "In the real world we have no difficulty identifying and distinguishing the terminally ill. They are patients who will die from a specific disease within a relatively short period of time." Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, Hastings Center Report (September-October 1993) at 22. *Accord Casey*, 505 U.S. at 869 ("Liberty must not be extinguished for want of a line that is clear.").

3. Abuse, Undue Influence, and the "Slippery Slope."

The State also raises the specter of abuse and undue influence. Pet. Br. 34. But, the same argument could be (and was) made in the abortion context, or, indeed, any

time an individual has a choice. The alleged risk here is no different than any risk associated with the refusal or withdrawal of life support. Even if there were a risk, the solution is not to eliminate individual choice and place absolute power in the hands of the state. The possibility of malicious third parties influencing the decision to hasten death does not nullify constitutional liberty interests.

The State further claims that affirming the constitutional right to physician aid in dying would "freeze the process of experimentation" and "forestall the opportunity to learn." Pet. Br. 49. Just the opposite is true. As the law currently stands, physician aid in dying is practiced covertly, outside of public scrutiny or discussion, and is more likely to be subject to abuse than if the practice were regulated by the state. Affirmation of the right to physician aid in dying would make the practice subject to reasonable regulations crafted to ensure that access to physician aid in dying is truly in the public interest and is not subject to abuse.

Similarly, the State and some of their *amici* warn that recognition of a liberty interest in physician aid in dying will necessarily result in people's lives being taken against their will. The State falls prey to the "slippery slope" because it refuses to focus on the specific and narrow group whose interests are at issue in this case – competent, terminally ill adults. Although the State may have a justifiable interest in ensuring that the lives of individuals are not taken against their will, that interest

has nothing to do with the right of competent, terminally ill individuals to voluntarily hasten death.[6]

B. State Interests Can Be Protected By Reasonable Regulation.

The State's absolute ban is not necessary to protect any lingering state interests. The alleged dangers of fraud, abuse, or error are avoidable through reasonable regulation of the right to receive aid in dying. As this Court recognized in *Casey*, "not every law which makes a right more difficult is, *ipso facto*, an infringement of that right." 505 U.S. at 873. Indeed, this Court has repeatedly recognized that constitutionally protected liberty interests may be subject to reasonable regulation. *See Loving v. Virgina*, 388 U.S. 1 (the right to marry is a protected liberty interest) and *Potter v. Murray City*, 760 F.2d 1065 (10th Cir.), *cert. denied*, 474 U.S. 849 (1985) (the government may bar polygamy); *Roe v. Wade*, 410 U.S. 113 (women have a constitutionally protected right to decide whether to carry a child to term) and *Casey*, 505 U.S. 833 (the state may impose certain restrictions on access to abortions). Here, regulated physician assisted death would provide protocols and safeguards missing in the present, covert, unregulated context.

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[6] Contrary to the concerns of some *amici*, recognition of a liberty interest in physician aid in dying does not mean that every medical professional will be required to assist every such patient who seeks assistance. Indeed, precisely because life and death decisions are so profoundly personal, such a requirement would arguably trespass upon the physician's own liberty interests.

Several models for regulation of access to aid in dying have been proposed. For instance, the Michigan Commission on Death and Dying, composed of members from all sections of the legal, medical and lay community, formulated a proposal that would permit terminally ill, competent people to seek aid in dying under tightly controlled circumstances. *Final Report of the Michigan Commission on Death and Dying*, June 8, 1994.[7] Under this approach, physician aid in dying would be available to a terminally ill person who made a recorded request for assistance in dying. The request would have to be reiterated to a physician and witnessed two more times, with at least seven days elapsing between the reiterations. Only the terminally ill individual could make the request, and no one else could influence or determine the timing of the assistance if it was given. *Final Report*, Section III, 3. The proposal also calls for psychological and spiritual counseling, aggressive pain management and counseling on independent living alternatives before an eligible person is permitted to act on his or her request to receive aid in dying. *See also* Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996) (imposing similar conditions to safeguard against misuse or abuse, including waiting period, corroboration, professional consultation, documentation and monitoring requirements).

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[7] The Michigan Commission produced three reports with different recommendations; none of the recommendations was endorsed by a majority of the members of the Commission.

C. The Washington Statute Unduly Burdens The Right Of A Mentally Competent Terminally Ill Adult To End Suffering By Hastening Death.

1. The State's Ban on Physician Aid in Dying Strips Many Terminally Ill Adults of Their Ability to Hasten Death.

The Washington statute prohibits physicians from assisting mentally competent, terminally ill individuals to hasten death.[8] Under the statute, a physician cannot prescribe medication to a terminally ill patient if the physician knows that the medication will be used to end the patient's life. While terminally ill people may be able, legally,[9] to hasten death through other means (by shooting themselves, for example), most terminally ill people are confined to institutions and do not have access to those means, are too weak to use them, or are averse to the violence these means often entail. Worse yet, the legal options currently available to the terminally ill are far less humane than the administration of medication that will hasten death.

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[8] The Washington statute states, "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." RCW 9A.36.060(1). Violation of this law is punishable by imprisonment for up to five years and by a maximum fine of $10,000. RCW 9A.36.060(2) and RCW 9A.20.020(1)(c).

[9] The act of suicide is not illegal in any state. *See* Maria T. CeloCruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 377 (1992). Only the act of assisting suicide is illegal.

Changes in medical technology and in the way that Americans die are important factors in the analysis of an individual's right to die:

> "[T]he timing of death – once a matter of fate – is now a matter of human choice." . . . Of the approximately 2 million people who die each year, 80% die in hospitals and long-term care institutions, and perhaps 70% of those after a decision to forgo life-sustaining treatment has been made. Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions.

Cruzan, 497 U.S. at 302-03 (Brennan, J., dissenting) (citations and footnotes omitted). Similarly, "[p]eople are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions." *Id.* at 339-40 (Stevens, J., dissenting).

Today, 80% of Americans – the vast majority of us – die in hospitals or long term care facilities, in many cases with little or no control over the end of our own lives. When we enter a hospital for the last time, we may have the strength, and technically, the legal right to end our lives if we wish. But once in the medical system, we often

lose the ability to help ourselves. Most of us have neither the knowledge nor the means to end our own lives in an acceptable way. We can't get life-ending substances for a dignified death, even if we knew how to use them. Thus, as a practical matter, competent terminally ill individuals frequently cannot exercise their right to hasten death without the assistance of a physician.

> To say the least, a ban on the use of physician-prescribed medications obviously places a substantial obstacle in the path of a terminally ill person seeking to hasten that person's inevitable death. Indeed, a more extreme burden on the exercise of that right cannot be imagined, and for this reason . . . the ban on the use of physician-prescribed medications is unconstitutional.

Sedler, *The Constitution and Hastening Inevitable Death* at 23.

The continuing criminalization of physician aid in dying hurts patients and their families and inhibits compassionate physicians from helping patients even when they are unable to cure their illnesses. The State insists on comparing a humane medical procedure to murder. Pet. Br. 6, 11 (assisted suicide laws "are generally considered part of the State's homicide laws . . . "; "[O]ne who intentionally acts to cause or contribute to another's death is with rare exceptions guilty of criminal conduct."). Thus the present system condemns dying people who cannot bear their pain any longer and makes closet felons out of compassionate doctors who respond to the last-resort requests of their suffering patients. One oncologist who repeatedly faced this dilemma stated:

> There are cases that stand out in my mind – more than ten – where I was helpless to relieve my patient's suffering, despite aggressive treatment. It made me feel awful. . . . Some of them made requests like "Put me out of my misery." Legally I couldn't do that. . . . I felt that I was abandoning them, but my hands were tied.

Sarah Henry, "Whose Life Is It, Anyway"? *California Lawyer*, September, 1996 at 32.

If the constitutionally protected right to hasten death is to have any meaning, it must include the right to physician assistance:

> The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. The right should . . . include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible. . . . If there is a time when we ought to be able to get the "government off our backs" it is when we face death – either by choice or otherwise.

Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1147-1148 (1986) (Compton, J., concurring).

The right of a competent, terminally ill person to physician assistance in dying is supported by constitutional jurisprudence and required by the reality of our modern world. To deny that right is to deny the most basic opportunity for self-determination.

2. The State's Ban on Physician Aid in Dying Can Devastate Terminally Ill People, Their Families, Friends and Physicians.

Under the current law, terminally ill patients who wish to hasten death are left with few options: (1) they can take their own lives through violent means, or (2) they can enlist the aid of friends and family members who may later be subject to criminal sanction.[10] This categorical ban on physician aid in dying only leads to greater suffering for the terminally ill and devastating consequences for family and friends. Like the back-alley abortions prevalent before *Roe v. Wade*, the State's categorical ban on physician aid in dying has not stopped terminally ill people from hastening death; it has merely forced them to choose violent and painful means of ending their suffering because no other options are available.

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[10] The assertion that pain can be controlled in most cases adds nothing. First, it says nothing about those terminally ill persons whose pain cannot be "controlled," and it is precisely these people for whom this case is perhaps most important. Second, it ignores the fact that pain control, in some instances, is achieved only with significant side effects such as confusion, hallucination, nausea, vomiting, constipation and respiratory depression. R. Hillier, M.D., *Control of Pain in Terminal Cancer*, British Medical Bulletin (1990) vol. 6, no. 1 at 279-91. To many, a choice between unbearable pain and loss of mental alertness may be no choice at all. "Living" under either condition may not be within the purview of what makes life worth living. Third, controlling pain is no answer for other kinds of suffering – the loss of dignity that may result from immobility, the inability to speak or swallow, incontinence, and the need for 24-hour-a-day care – that often motivate competent, terminally ill adults to seek physician assistance in hastening death.

> Self-inflicted gunshot, hanging, and asphyxiation all occur, though they may require more strength and energy than many terminally ill patients possess. If successful, patients who use these means to end their lives at least put an end (if gruesome) to their suffering. The victims more often are the families, who may both literally and figuratively have to pick up the pieces.

Quill, *Death and Dignity: Making Choices and Taking Charge*, 114.

Although the State refers to dying, suffering persons as "hypothetical people," Pet. Br. 10, 39, 40, there is nothing hypothetical about the dying people who originally brought this suit. Nor is there anything hypothetical about Bill, an energetic man in his mid-70s, who was dying from throat cancer. After 18 months of treatment, the tumor had spread to Bill's brain and sinuses and Bill had permanently lost most of his hearing, could not swallow solid foods or liquids, had constant headaches, and the drainage from his nose was so severe that he had to wear a pad. After two years of progressive deterioration and indignity, Bill decided to take his life. Since he did not want to subject his friends and family to criminal sanction, he shot himself in the head. After hearing the gunshot, Bill's wife found him, horribly wounded, but still alive. Bill died at the hospital three hours later. *See* Quill, *Death and Dignity: Making Choices and Taking Charge*, 117-120.

Moreover, terminally ill individuals who are determined to end their suffering frequently turn for help to friends or family members who may be subject to criminal sanctions. Another typical example is the story of

Steven who, just shy of his 40th birthday, was dying of AIDS. He enlisted the assistance of an HIV-positive friend. On the appointed night, Steven threw a wake party which was attended by many supportive friends and family. But the plan Steven and his friend had agreed upon went awry. Steven's friend got drunk and became increasingly distraught. When the friend nonetheless began to honor his commitment to Steven, he was interrupted mid-injection by someone and promptly left the house. Those remaining at the party were forced to call a physician who reluctantly told them how to complete Steven's directive. They all faced the risk of criminal liability. *See* Lori Olszewski, *One Man's Choice*, San Francisco Chronicle, Oct. 19, 1992.

The stories of Bill and Steven are not hypothetical or unique, and they did not have to happen. If Bill and Steven had been able to request the assistance of a physician, they could have ended their lives painlessly, with dignity, and without jeopardizing their loved ones. Despite the state's generalized interests in the "preservation of life," the state had no interest in prolonging the dying process for either of these men. Bill and Steven were not abstractions. They were people who had a right to determine how they would die. As Justice Stevens stated in *Cruzan*, 497 U.S. at 356-57 (Stevens, J., dissenting):

> However commendable may be the State's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes. Lives do not exist in

> abstraction from persons, and to pretend otherwise is not to honor but to desecrate the State's responsibility for protecting life.

Physician aid in dying for mentally competent terminally ill adults lets dying people be treated as individuals and not as abstractions. No state has a paramount interest in prolonging the suffering of a terminally ill adult who has competently made the decision to end the dying process.

CONCLUSION

The decision of the United States Court of Appeals for the Ninth Circuit should be affirmed.

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Respectfully submitted,

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